Central **LHIN**

Advancing better health services for all

2011/12 Annual Report

Ontario
Local Health Integration Network

Advancing better health services for all

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the provincial government through the *Local Health System Integration Act (LHSIA), 2006*, to plan, coordinate, integrate and fund health services at the local level.

LHINs reflect the idea that communities know their own health needs and priorities best. They bring together health care partners from sectors such as hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care to develop innovative, collaborative solutions leading to achieve more timely access to high-quality services for the people in our communities.

By supporting these important partnerships, LHINs work to enable Ontarians to have access to an effective and efficient health care system that delivers improved health care results and a better patient experience. Because of the LHINs:

- Providers in the local health care system are working **together to improve access to quality care** for Ontario residents;
- The **health care needs of people in the local community are being identified, co-ordinated and addressed as a truly integrated system**. This means we are working toward people receiving the **right care, at the right time, in the right place**, and **greater access to care**;
- Local decisions are being made at the Board level to respond to local health care needs; and
- Health service providers are being **held accountable for the taxpayer dollars** they are given. LHINs enable this through Service Accountability Agreements with each health service provider, and in turn are accountable to the Ministry of Health and Long-Term Care through Minstry-LHIN Performance Agreements.

Visit www.lhins.on.ca for more information on how LHINs are making a difference.

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Message from the Chair and CEO

Canadians value health care as an important contributor to our quality of life. Providing people with the right care at the right time and in the right place is essential for achieving a high-quality, person-centred health system and for managing health care costs. As a funder, planner and manager of the local health system for South Simcoe, York Region and the north end of Toronto, Central LHIN addresses the health needs of our communities. We support *Ontario's Action Plan For Health Care*, a road map for the transformation to a smarter and more efficient health care system leading to better health outcomes.

Together, our health service providers, staff and Board of Directors are doing what we can to direct health dollars to where they are needed most. Guided by the framework outlined in our Integrated Health Service Plan for 2010-2013, Central LHIN continues to focus on four planning priorities: Emergency Department and Alternate Level of Care (ALC); Chronic Disease Management and Prevention; Mental Health and Addictions; and Health Equity.

In 2011/12, Central LHIN continued to make significant progress in key areas that advanced the Healthy Seniors, Healthy Communities strategy. Medically stable patients were provided with necessary supports so they could go home, and ICU beds were able to be used by more critically ill patients. More community supports were offered to more people after receiving advanced care so they could stay in their own home instead of being moved to a nursing home. These and other initiatives enabled $65 million to be redirected into other areas of our local health system.

Access to the services important to people in our communities is improving. For example:

- Central LHIN met all provincial surgical and diagnostic wait time targets in the fourth quarter 2011/12 through an integrated approach to making the best use of our local resources and capacity and, year over year, achieved the lowest emergency department wait time in Ontario for "non complex" issues;
- Expanded access to Home First, an enhanced care service offered by the Central Community Care Access Centre (CCAC) in partnership with Central LHIN hospitals. More than 1,240 people have been served since September 2010; on average, 68 per cent of Home First clients remain in the community after receiving advanced care, thus reducing the need for long-term care;
- People with mental health and addictions issues often face a number of barriers when accessing care. To address this, local health service providers, supported by Central LHIN, continued to develop and refine anti-stigma curriculum, training and promotional materials that have been replicated in other jurisdictions and adopted by the Mental Health Commission of Canada's 10-year Opening Minds program; and
- Central LHIN launched *Patients First: An Action Plan to Improve Quality in the Transitions of Care*, a forward-looking document that sets out our approach to advancing quality across the local health system in support of provincial quality directions.

In line with the government's plan to move more services from hospitals into communities and because we recognize that access to primary care is the best way to achieve better health outcomes, we are collaborating with doctors, family health teams, nurses and other providers to find ways to integrate care better for people and their families.

Looking forward, Central LHIN will work with our health service providers and key stakeholders to meet the health needs of our communities. We will have an enhanced focus on: improving access to primary care; preventing hospital readmissions; supporting seniors to stay healthy and home longer; collaborating with primary care providers to find ways to better integrate care; and working across LHINs and other ministries to address service gaps and improve transitions of care for people.

Because we believe community engagement is fundamental to enabling collaboration, we will continue to engage with our stakeholders and communities to gain input into the decisions and plans being made about local health care.

Thank you to our health service providers, our Board of Directors and our staff for their sustained effort and commitment to advancing excellent care for all in Central LHIN.

Together. We're Better.

John Langs

Chairman of the Board of Directors

Kim Baker

Chief Executive Officer

Our Board of Directors

LHINs operate as not-for-profit crown agencies governed by an appointed Board of Directors and are bound by a Ministry-LHIN Performance Agreement and Memorandum of Understanding with the Ministry of Health and Long-Term Care. Board members are appointed by an Order-in-Council for a term of one to three years, subject to a maximum of two terms (up to six years).

The role of the LHIN Board of Directors is to oversee, provide advice on and govern the strategic direction and priorities of the LHIN. The Board of Directors is accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds, and for its performance results in the local health system.

In May 2011, Central LHIN welcomed Mr. John M. Langs, a member of the Central LHIN Board since 2008, as Board Chair. Also in May, five new members were appointed, as previous members' terms expired. Over the past year, the Central LHIN Board has had a complement of eight members.

Details on the Central LHIN Board of Directors can be found at http://www.centrallhin.on.ca.

John M. Langs – Chairman
June 2, 2011 – June 2, 2014
Toronto

Dr. Uzo Anucha
June 2, 2011 – June 1, 2014
Richmond Hill

Judy Cameron
June 2, 2011 – June 2, 2013
Keswick

Albert Liang
May 17, 2011 – May 16, 2014
Markham

Maneesh Mehta
June 17, 2010 – June 17, 2013
Unionville

Stephen E. Quinlan
June 23, 2011 – June 22,2014
Sharon

John Rogers
Mar. 10, 2010 – Mar. 10, 2013
Keswick

Brenda Urbanski
April 8, 2011 – April 8, 2014
Beeton

Kenneth A. Morrison –
Inaugural Chairman
June 2, 2005 – June 1, 2011
Newmarket

Arthur W. Walker –
Inaugural Vice- Chair
June 2, 2005 – June 1, 2011
Bradford

Sandy Keshen –
Inaugural Board Secretary
June 2, 2005 – June 1, 2011
Richmond Hill

Raksha Bhayana
May 17, 2006 – May 16, 2011
Thornhill

About Central LHIN

In 2011/12, Central LHIN's funding allocation of $1.8 billion was allocated across a range of health programs through 112 Service Accountability Agreements, delivered by our health service providers, including:

- Seven public and three private hospitals;
- 46 long-term care homes;
- 33 community support service providers;
- 20 mental health and addictions service providers;
- One community care access centre (CCAC); and
- Two community health centres.

Many health service providers deliver care and services in multiple sectors.

Population

With 1.8 million* residents, Central LHIN is the most populous and one of the fastest growing LHINs in Ontario. Central LHIN is also one of the smallest LHINs geographically, covering an area of 2,730.49 square kilometers; our population density is 40 times greater than that of the provincial average.

Demographic trends impacting services

Examining Central LHIN's health profile helps us work towards our goal of reducing health disparities and ensuring equitable access to quality health care in our communities by identifying populations that would benefit from focused initiatives.

Growth, aging and diversity are the population trends in Central LHIN that will have significant impact on planning and delivery of health services. A key challenge is to meet the increasing demand for care and services as our population continues to grow and age at a rate above the provincial average.

Growth

Central LHIN's population is growing. Over the next 10 years, we will experience an increase of 20 per cent* in the total number of people living in the LHIN, which is higher than the provincial average of 14 per cent*.

Aging

Our population is aging. Over the next 10 years, people in Central LHIN communities over the age of 65 will increase by approximately 57 per cent*. This means we will have an additional 136,000* seniors by 2022, bringing the total population of seniors to 375,000*.

Diversity

About 49 per cent* of Central LHIN's population is comprised of immigrants. This is the highest proportion among the LHINs. Over the next 10 years, with an additional 200,000* newcomers expected to enrich our communities by 2022, the leading source countries* for growth will be for people from China, India, Philippines, Iran, Pakistan and Sri Lanka (in descending order by number of newcomers).

Central LHIN's population of visible minorities is 45 per cent*. The number of visible minorities is projected to grow by 260,000* over the next 10 years, so that by 2022 half of all people living in the LHIN will be visible minorities.

Aboriginal community

Central LHIN has a relatively small Aboriginal/First Nations population – just under 0.5 per cent of our population, or 7,000 people. The vast majority of Central LHIN Aboriginal people live off reserve, with only 210 on reserve. Our First Nations community resides primarily in the northern section of our LHIN on Georgina Island and in South Simcoe County.

Francophone community

Central LHIN's current proportion of Francophones is approximately 3.2 per cent, or 56,000 people. A more inclusive definition of "Francophone" was adopted in 2009. Currently, the term also includes those whose mother tongue is neither French nor English, but who speak French at home or who come from a place where French is an official language.

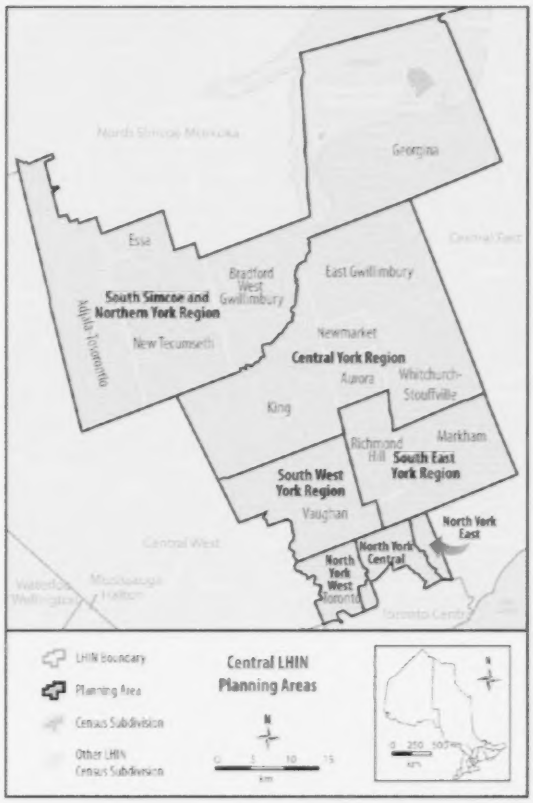
Varied geography

Central LHIN is geographically diverse. While approximately 70 per cent of our population is urban – residing in North Toronto, Vaughan, Richmond Hill and Markham, there is a significant rural region to the north which can present geographic challenges to residents seeking to access services close to home in those areas.

*Source: *Environics Analytics 2012*

Central LHIN's planning areas

Central LHIN's geography is divided into seven planning areas, for planning purposes only, as illustrated by the map below. These areas vary in size, demography and social characteristics. Because Central LHIN's planning areas are so different from one to another, each has its own unique challenges and needs that have to be considered when planning at a system level.



Health profile

Generally, our residents have a lower incidence of chronic disease and conditions such as high blood pressure, heart disease, arthritis and asthma than that of Ontario as a whole. However, Central LHIN has the highest percentage of adults with diabetes (13.51 per cent)* by LHIN. The highest rate is in a largely rural census subdivision in the north-central part of the LHIN.

Within our planning areas, there are disparities in health status due to varying levels of education, unemployment and risk behaviours such as smoking and obesity, all of which have been shown to influence human health.

According to the Canadian Institutes of Health Research, high-risk populations are groups of people that share characteristics associated with a higher risk of adverse health outcomes – such as homelessness, single women living in poverty or lone-parent families.

Two of our planning areas – South Simcoe / Northern York Region, and North York West – have been identified as higher-risk areas from a population health standpoint. A greater number of residents in these two planning areas face serious chronic diseases, as well as obstacles to accessing primary care, compared to other planning areas in the LHIN.

*Source: *Regional Measures of Diabetes Burden in Ontario*, Institute for Clinical Evaluative Sciences, April 2012

Central LHIN population factors by planning areas

Community		South Simcoe and Northern York Region	Central York Region	South East York Region	South West York Region	North York West Region	North York Central Region	North York East Region	Central LHIN (total)	Ontario
Population		113,257	204,207	465,683	230,536	237,884	276,973	123,141	1,651,681	12,986,332
Largest municipality (by population)		Georgina (York Region)	Newmarket (York Region)	Markham (York Region)	Vaughan (York Region)	North York (Toronto)	North York (Toronto)	North York (Toronto)	York Region	Toronto
Profile	Immigrant:	14%	21%	54%	45%	59%	56%	63%	48%	23%
	Senior:	11%	11%	10%	9%	15%	17%	14%	13%	14%
	Francophone*:	1%	2%	1%	1%	1%	1%	1%	1%	4%
	Aboriginal:	1.4%	0.8%	0.4%	0.1%	0.4%	0.2%	0.2%	0.4%	2%

Source: KPMG Central LHIN Health Service Needs Assessment and Gap Analysis 2008

*In 2009, the term "Francophone" was expanded to include those who speak French at home or who come from a place where French is an official language in addition to those whose mother tongue in French. Under the new definition, Central LHIN's current proportion of Francophones is approximately 3.2 per cent. The data used for this chart was compiled in 2008, before the term was redefined.

Central LHIN's role as a health system funder

Central LHIN is committed to transparent, responsive and accountable health spending. We work with our stakeholders to plan investments that put local health dollars where they are most needed to improve the accessibility, coordination, quality and efficiency of our local health system for patients and their families.

Approximately $5 million is invested into our local health system *every day* in the form of health services delivery

Health Service Provider funding allocation

In 2011/12, Central LHIN authorized transfer payments of $1,824,986,446 (2010/11 - $1,760,411,514) to the following sectors, which represents an increase of 3.7 per cent over the previous year:

Sector	2011-2012	2010-2011
Hospitals	$1,135,136,035	$1,106,535,927
Long-term Care Homes	$311,945,250	$296,523,547
Community Care Access Centre	$229,474,894	$214,073,634
Community Support Services	$71,997,394	$69,137,969
Community Health Centres	$8,500,437	$7,666,837
Community Mental Health and Addictions Agencies	$67,932,436	$66,473,600
TOTAL	**$1,824,986,446**	**$1,760,411,514**

Health system accountability

LHINs enhance system accountability for public funds through the development and execution of Service Accountability Agreements (SAAs) with our health service providers, and through the LHIN's Ministry-LHIN Performance Agreement with the Ministry of Health and Long-Term Care.

These agreements set out funding and performance deliverables for local services that are aligned with LHIN and Ministry of Health and Long-Term Care priorities.

In 2011/12, Central LHIN had 112 current SAAs across all sectors and providers.

Ultimately, these agreements support system collaboration to enhance stability and accountability in the health system. They also help us to build a better local health care system that emphasizes quality care for people and their families that is delivered within available resources.

Investing in additional procedures

In 2011/12, Central LHIN worked with our local hospitals to invest $32 million to perform:

- ✓ 29,326 MRI hours
- ✓ 9,121 CT hours
- ✓ 5,380 cataract surgeries
- ✓ 1,643 joint replacement surgeries
- ✓ 708 cancer surgeries
- ✓ 418 general surgeries
- ✓ 147 paediatric surgeries
- ✓ 34 cardiac by-pass surgeries

Timely access to care is critical, and receiving care in the most appropriate setting allows faster access to care when needed. That is why wait times remain both a provincial and Central LHIN priority.

Over the 2011/12 fiscal year, Central LHIN has taken an integrated approach to making the best use of our local resources and capacity. The Ministry of Health and Long-Term Care, Central LHIN and local hospitals have been working together to continually shorten wait times.

At the end of the fourth quarter, wait times for a number of procedures improved from the previous year, including cancer and cataract surgeries, hip replacement procedures, and diagnostic MRI and CT scans.

Wait times were also shortened for people who were treated and then discharged from the emergency department despite an increasing number of very sick individuals coming to the emergency department. All of our wait times were favourable compared to the provincial average.

Central LHIN had the best* year-over-year results in the province at 3.73 hours for the 90th percentile** emergency room (ER) length of stay for non-admitted, minor uncomplicated patients.

In 2011/12, major progress was made in discharging patients with very long stays in acute care hospitals. This was achieved through new physical bed capacity created through the home ventilation program, behavioural support unit, transitional care bed program, and community alternatives to long term care such as the **Home First** program.

Central LHIN continues to work with our health service providers to improve wait times and the care experience for people in our communities.

* Tied for first place with Mississauga Halton LHIN

**90% of people are served within these time frames

"I am proud of the work that Central LHIN hospitals are doing together to test, share and adapt best practices in an effort to drive effective and sustainable improvements in emergency department wait times. We expect to see positive results from a renewed focus on improving patient flow that involves collaboration throughout the entire hospital and across the system to find ways to improve discharge processes and care transitions."

– Dr. Rakesh Kumar,
Central LHIN Emergency Department Lead

Improving access to care

(fourth quarter 2011/12)

- ✓ Non-admitted patients visiting Central LHIN's emergency departments are being seen within **3.73 hours** – that's the **fastest result in Ontario*.**
- ✓ **Cancer surgery** wait times *decreased* by 7.3%
- ✓ **Cataract surgery** wait times *decreased* by 10.1%
- ✓ **Hip Replacement surgery** wait times *decreased* by 12.7%
- ✓ **Knee Replacement surgery** wait times *decreased* by 10.2%
- ✓ **Diagnostic MRI scan** wait times *decreased* by 48.8%
- ✓ **Diagnostic CT scan** wait times *decreased* by 16.1%
- ✓ **Cardiac By-Pass surgery** wait times *decreased* by 34.4%.

Shorter emergency department visits

(fourth quarter 2011/12)

- ✓ 90th Percentile ER Wait Times for **high acuity admitted patients** *improved* by 8.0 %
- ✓ 90th Percentile ER Wait Times for **non-admitted high acuity patients** treated *improved* by 5.2%
- ✓ 90th Percentile ER Wait Times for **non-admitted low acuity patients** *improved* by 3.6%

LHIN performance and targets as defined by the Province of Ontario

2011/12 Performance Indicators	Starting point	Performance target	Most recent quarter	% from target for most recent quarter result*	Annual result
Emergency Room/Alternate Level of Care					
Percentage of Alternate Level of Care (ALC****) Days - By LHIN of Institution***	16.10%	13.01%	17.52%	34.6%	15.64%
90th Percentile ER Length of Stay for Admitted Patients	44.28	36.00	44.97	24.9%	40.75
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.83	7.83	7.57	-3.4%	7.42
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	3.90	3.90	3.87	-0.9%	3.73
Surgical Wait Times					
90th Percentile Wait Times for Cancer Surgery	46	47	38	-19.1%	41
90th Percentile Wait Times for Cardiac By-Pass Procedures	64	63	40	-36.5%	55
90th Percentile Wait Times for Cataract Surgery	102	102	80	-21.6%	80
90th Percentile Wait Times for Hip Replacement	150	139	131	-5.8%	141
90th Percentile Wait Times for Knee Replacement	162	154	150	-2.6%	160
Diagnostic Wait Times					
90th Percentile Wait Times for Diagnostic MRI Scan	147	112	66	-41.1%	102
90th Percentile Wait Times for Diagnostic CT Scan	37	34	26	-23.5%	30
Excellent Care for All / Quality					
Readmission within 30 Days for Selected CMGs**, *****	15.19%	14.40%	16.14%	12.1%	15.13%
Mental Health and Substance Abuse					
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	17.90%	17.00%	17.68%	4.0%	17.11%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	20.70%	19.70%	20.53%	4.2%	18.88%
Access to Community Care					
90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	39.00	37.10	23.00	-38.0%	25.00

* A negative percentage means the LHIN is below its target

** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability

*** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability

**** ALC definition, Province of Ontario: When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period is determined by the hospital and starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

***** CMG: Case Mix Group is a methodology designed to aggregate hospital inpatients with similar diagnoses and treatment requirements. CMG is a registered trademark of the Canadian Institute for Health Information.

Reducing the time people spend waiting in a hospital emergency department for care is a complex issue that is both a provincial and Central LHIN priority.

Improving access in the emergency department depends in part on a hospital's ability to either admit patients to its acute care beds, to discharge patients to other appropriate care settings, or to safely send them home with the assistance of home-based care, if needed.

Central LHIN and its health service providers are focused on improving emergency department efficiency and capacity, and reducing the time spent in acute care beds waiting for alternate levels of care.

Enhancing emergency room capacity

In 2011/12, Central LHIN invested in programs under the **Aging at Home** strategy, and participated in provincial emergency room (ER) programs designed to help meet the following ER provincial targets:

- Reduce 90th Percentile ER Length of Stay for Admitted Patients;
- Reduce 90th Percentile ER Length of Stay for Non-Admitted, High Acuity Patients; and
- Reduce 90th Percentile ER Length of Stay for Non-Admitted, Low Acuity Patients.

Emergency Department Pay for Results (Year 4)

In 2011/12, Central LHIN was allocated $9.3 million as part of the **Emergency Department Pay for Results** one-time fixed funding. In addition, the Ministry of Health and Long-Term Care provided further performance incentives such as variable funding as another component of the Pay for Results Year 4 program. This provided hospitals with the opportunity to receive additional funding based on their performance improvement in meeting specific wait time targets.

Pay for Results funding was directed toward initiatives to help reduce emergency department length of stay and to improve patient satisfaction. The Central CCAC and all six Central LHIN acute care hospitals participated in the program. They included: Humber River Regional Health Centre (Church and Finch sites), Markham Stouffville Hospital, North York General Hospital, Southlake Regional Health Centre, Stevenson Memorial Hospital and York Central Hospital.

The focus on the Pay for Results Year 4 program resulted in improvements compared to the baseline (2010/11). For example, the emergency department wait times for admitted high acuity (seriously ill) patients improved by eight per cent, or three and a half hours. The emergency department wait times for non-admitted patients with complex and minor uncomplicated conditions both improved by more than 5.2 per cent for non-admitted high-acuity patients and 3.6 per cent for non-admitted low acuity patients. This accomplishment was achieved even though Central LHIN's number of emergency department visits increased by 4.7 per cent and admitted patients increased by 3.1 per cent compared to the previous year.

Emergency Department Process Improvement Program (ED-PIP Wave 4)

In 2011/12, Central LHIN supported Markham Stouffville Hospital in the fourth phase of the provincial ED-PIP initiative, which was introduced to address the challenges patients face in accessing timely ED care. The objectives of this program include:

- Reducing emergency department wait times;
- Improving patient satisfaction;
- Improving hospital work environment; and
- Building capacity for continuous quality improvement and sharing of best practices.

For Markham Stouffville Hospital, the success of the ED-PIP was demonstrated with improvement achieved for reducing ER wait times for the Emergency Department Pay for Results Non-Admitted indicators compared to the previous year.

Integrated Health Service Plan (IHSP) priorities

In 2011/12, Central LHIN continued to direct available resources towards making progress in the priorities identified in our IHSP 2010-13. As defined in the plan, Central LHIN's key areas of focus are:

- Emergency Department and Alternate Level of Care
- Chronic Disease Management and Prevention
- Mental Health and Addictions
- Health Equity

Emergency Department / Alternate Level of Care (ED/ALC)

In the past year, Central LHIN continued to develop a more sustainable health system for seniors by:

- Supporting provincial priorities to reduce ED wait times and ALC pressures;
- Leveraging **Aging at Home** to support IHSP priorities;
- Building service capacity;
- Addressing gaps in seniors care;
- Strengthening linkages between our health service providers and community leaders outside the traditional health sector;
- Supporting disadvantaged and underserviced groups;
- Targeting opportunities that support our Accountability Agreement indicators and Ministry priorities;
- Advancing emergency department quality improvement efforts with knowledge exchange forums on *Emergency Department Flow and Infection Control Best Practices*; and
- Implementing the first phase of the **Senior Friendly Hospitals Strategy** to enable seniors to maintain optimal health and function while they are hospitalized so they can transition successfully home or to the next level of care.

Continuing to reduce ALC pressures

When patients no longer need acute care in our hospitals, they often remain in acute care beds while waiting to be discharged or transferred. They need an "alternate level of care" (ALC) such as long-term care, home care or rehabilitation.

Aging at Home

In the 2011/12 fiscal year, Central LHIN invested $52.9 million through 62 **Aging at Home** initiatives to address key LHIN and government priorities, including reducing ED and ALC pressures, and continuing key community-based services. Highlights included:

- Creating 145 new transitional care beds to assist with people who are discharged from the hospital to long-term care and are waiting for the Central CCAC to facilitate the care management plan;
- Funding **Home First**, which in 2011/12 enabled 786 people to return home from the hospital instead of going to a long-term care home. Since the program started, a total of 1,240 clients have been assisted.
- The **Transitional Home Ventilation Service** at West Park Healthcare Centre admitted a total of 18 clients from Central LHIN and several surrounding LHINs. Seventeen clients have been successfully transitioned out of hospital to now live successfully in the community. This has freed up ICU beds to provide critical care. Through this service, 5,171 ALC days in acute care were avoided.
- The **Falls Prevention** program conducted 258 initial in-home safety assessments. And, through the award-winning Central CCAC's **Medication Management Support Services** (MMSS), approximately 1,700 seniors received home visits to review their medications and improve their ability to manage and understand the medications they were taking, thus reducing potential adverse drug reactions and falls – common causes of ED visits among seniors.

In 2011/12, Central LHIN continued to work with our health service providers and the Ministry of Health and Long-Term Care to build capacity in our local health system to ensure that people get the care they need: in a hospital, in a rehabilitation or long-term care setting, in the community or at home. Specific related initiatives include:

- Continuing with **"assess and restore" programs** aimed at restoring and reactivating an elderly patient's level of functioning and creating opportunities for them to be transferred home from the hospital with appropriate ongoing supports.
- Continuing to implement the **Senior Friendly Hospital Strategy**: Considering that many frail elderly patients enter the acute care system through the emergency department, hospitals have an integral role to play in their care, therefore need to continue to embrace "Senior Friendly" care principles.

  In 2011/12 Central LHIN hospitals completed a self-assessment of Senior Friendly care. With this information, reports on Senior Friendly Care in the Central LHIN and in Ontario were published, identifying strengths, as well as priorities for improvement.

  Some hospitals in Central LHIN have implemented elder friendly programs such as **the Hospital Elder Life Program (HELP)**. Others are incorporating Senior Friendly design principles in their planning among other leading practices.

  Hospitals are currently looking at promising practices related to functional decline and delirium, and will identify areas for improvement. Central LHIN hospitals are also working at applying best practices related to discharge planning to help improve transitions in care.
- A **hospital-led system-wide initiative** is currently underway to address patients waiting in acute care for rehabilitation services and the adoption of rehabilitation best practices for certain high-volume patient populations (total joint replacement, stroke and hip fracture).

  Through this work, hospitals, working together with the LHIN, will identify practices and strategies that will optimize patient access to rehabilitation at the right time and place with the right providers so that the best possible functional outcomes can be achieved.

  This initiative is aligned with similar work in other LHINs across the province and the Ministry's Rehabilitation and Complex Continuing Care Expert Panel recommendations.

Central LHIN enhancements to improve the ALC situation:

✓ **LOFT Crosslinks Seniors Housing and Support Services**

Six Reintegration Units serve older adults with serious mental health, substance use or addictions challenges who are in hospital and require transitional support services. From the time of implementation of these units in January 2010, a total of 50 clients were successfully transitioned from hospital to the community.

✓ **Behavioural Supports Ontario**

In 2011/12, Central LHIN supported eight additional Behavioural Support Beds at Cummer Lodge, increasing the number of beds in long-term care that are supported by an inter-disciplinary team, including enhanced specialized nursing care and a range of allied health professionals, from eight to 16.

✓ **Home First expansion with the Central CCAC**

Because people in our communities told us they want to be home, the **Home First** program was expanded in 2011/12. As one of the first LHINs to implement this initiative, Home First **had served over 1,240 people** in Central LHIN as of March 2012.

✓ **West Park Transitional Home Ventilation Service**

The **West Park Transitional Home Ventilation Service** has brought 17 people home and created greater capacity of about 5,171 days in hospital intensive care units.

Chronic disease management and prevention

Chronic diseases such as diabetes, congestive heart failure, arthritis and stroke have significant personal, social and economic impacts. Treatment of chronic diseases and their complications places significant demand on our acute care system and community-based services – a demand that is expected to increase with the aging of our population.

Central LHIN is committed to improving access to diabetes, renal and stroke care by supporting the implementation of the Ontario Diabetes Strategy, the Ontario Renal Network and the Ontario Stroke Network, streamlining the delivery system and putting a plan in place to support self-management.

Successes in this area in 2011/12 included:

- Supporting the **Central LHIN Diabetes Regional Coordination Centre** in using local resources and existing expertise to develop and maintain an integrated, coordinated system for the prevention and management of diabetes;
- Pilot testing a training program through **the Ontario Diabetes Strategy Self-Management Initiative** in Central LHIN for people living with a mental illness and who are at risk of developing or have developed diabetes;
- Supporting the **Central LHIN Regional Renal Network** to plan, coordinate and support quality improvement for the delivery of renal services across our LHIN;
- Expanding the five **stroke prevention clinics** to include access to cardiovascular rehabilitation services targeting underserviced areas in Central LHIN; and
- Supporting collaboration across our hospitals to develop an **action plan around enhancing timely access** to rehabilitation services to improve outcomes for stroke patients across our LHIN.

Mental health and addictions

Helping people with mental illness and addictions access the supports they need is an ongoing challenge. Central LHIN continues to focus resources where they make the greatest impact – coordinating care, bridging gaps in the system, reducing wait times for assessment and services, and enhancing community supports.

Central LHIN's goals and priorities are consistent with the provincial government's **Comprehensive Mental Health and Addictions Strategy** that includes supporting programs and initiatives that improve the health and well-being of all Ontarians, reduce the incidence of mental illness and addictions, identify mental health and addictions early, and intervene appropriately.

2011/12 successes in this area included:

- Continuing the **Emergency Department Diversion Program** at North York General Hospital and Humber River Regional Hospital, an initiative which focuses on improving the coordination of care delivery between acute care and community-based supports for mental health clients;
- Increasing the number of supportive housing units with the **LOFT Community Services Assisted Living Program** to 50 seniors with mental health and addictions challenges at the Jane/Finch hub and a new site in Bradford;
- Expanding the **community mental health eating disorders programs**, including the addition of three new nurse practitioners, more paediatric inpatient beds and enhanced adult outpatient services across Central LHIN;
- Expanding the **community mental health early psychosis intervention programs** in Central LHIN to increase access for children and youth;
- Continuing the **Centralized Access Program** – through York Support Services Network and Toronto North Support Services – to coordinate and monitor case management services, assessment and triage, system navigation, peer support, match coordination and centralized waitlist management;
- Expanding the **Anti-Stigma Project** to explore strategies to impact organizational culture around stigmatizing behaviours; and
- Supporting the **Behavioural Supports Ontario** project to enhance services for people with behaviours associated with complex and challenging mental health, dementia or other neurological conditions.

Behavioural Supports Ontario (BSO) Project

Central LHIN's population is aging and the number of people with cognitive impairment is growing. A $40 million investment from the Ministry of Health and Long-Term Care, **$3.97 million of which has been allocated to Central LHIN**, is enabling local health care providers to hire new staff – nurses, personal support workers, occupational therapists, social workers and other health care providers – and train them in the specialized skills necessary to provide care for people with complex and challenging behaviours associated with mental health, dementia or other neurological conditions.

BSO accomplishments in 2011/12 included:

- Multiple engagement events with stakeholders to develop a Central LHIN Local Action Plan;
- Collaboration between health service providers to develop a behavioural support system and identify opportunities to work more closely to enhance client outcomes;
- Education for approximately 900 front-line staff on caring for clients/residents with challenging and complex behaviours; and
- 50 new staff were hired to the mobile support teams and expanded long-term care resources.

As part of its BSO Action Plan, Central LHIN is building capacity and ensuring that staff in long-term care homes, hospitals and community agencies have the skills needed to respond to residents and clients with behavioural issues. Specific investments include enhancing a specialized behavioural unit in long-term care, as well as building on local behavioural services and expertise to establish interdisciplinary Behavioural Support Teams across Central LHIN.

Supporting neurological services

People with neurological-related conditions – such as stroke, acquired brain injury or Alzheimer's disease – require timely access to appropriate care and services.

2011/12 milestones in this area include:

- Expanding **adult day programs for people with acquired brain injury or aphasia,** including access to programs for clients with the highest level of complexity;
- Enhancing access to **Alzheimer Day Programs** through the First Link referral program; and
- Expanding the availability of **dementia adult day programs** across the LHIN to support clients and their caregivers.

Central LHIN anti-stigma program goes national

In 2011, Central LHIN developed a workshop entitled *Mental Illness and Addictions: Understanding the Impact of Stigma.* The primary objective of this education strategy was to address the stigma associated with mental illness and addictions, and its impact on people.

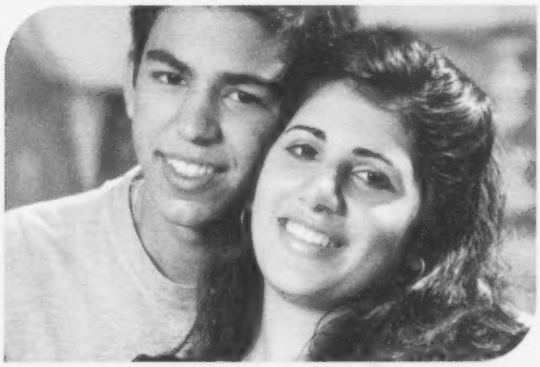
Proven to be effective at reducing stigma, the Mental Health Commission of Canada has adopted the Central LHIN model through a ten-year anti-stigma program called **Opening Minds**. The Central LHIN program has also been implemented in other health regions across Canada including seven communities in British Columbia.

"For those living with mental illness and addictions, the most devastating impact on their lives is often not from the illness itself but rather from the way others in society treat them. Unfortunately, the need to know more about mental illness and addictions, and the associated stigma, does not just affect the average person – it is an issue that health care professionals struggle with as well. This program has begun to make a difference in changing attitudes and perceptions amongst health care professionals."

– Jody Hamilton, Project Consultant for Centre for Addiction and Mental Health

Health equity

Central LHIN's health equity priority aims to reduce health service inequities and improve access to care within certain population groups in key planning areas identified as having higher-than-average incidence of serious health conditions and challenges in accessing primary care.



The priority includes the objective of collaborative planning with other ministries, such as the Ministry of Community and Social Services and the Ministry of Child and Youth Services. Over the past year, key successes achieved in support of the health equity priority included:

- Three new **family health teams** (Don Mills, Humber River Regional Hospital and Woodbridge Medical Centre) and two **Nurse-Practitioner Led Clinics** (Sutton and North York West) became fully operational;
- Central LHIN participated in the **Provincial Aboriginal Planning Session** as well as Pan-LHIN Aboriginal Cultural Awareness training;
- An **updated framework and first set of hospital health equity reports** were produced. An updated framework and first set of community support service sector health equity plans were produced. Both frameworks were developed collaboratively with health service providers;
- A Joint Action Plan was developed with **the Entité de planification des services de santé en français #4 Centre Sud-Ouest** and in collaboration with North Simcoe Muskoka and Central East LHINs;
- A **Health Equity Visioning Session** was held in partnership with the Department of Equity Studies at York University to identify key priorities for improving health equity in Central LHIN. Based on recommendations from the Session, a new multi-disciplinary planning group was established to advise on the development of a **Central LHIN Newcomer Settlement Strategy**;
- Two **primary care engagement sessions** were conducted – the first related to **diabetes management** for physicians in partnership with the Ontario Medical Association, and the second in collaboration with the residents of Georgina Island and the Central Diabetes Regional Coordination Centre related to addressing **First Nations' health needs**;
- **Matching of unattached** patients to a primary care provider through Health Care Connect **improved by approximately 10 per cent** over the past year; and
- **The Health Equity Impact Assessment tool** was successfully piloted as part of ongoing LHIN Request for Proposal (RFP) processes and in the proposal for a voluntary integration of St. John's Rehab Hospital and Sunnybrook Health Sciences Centre.

Integration

Pursuing service integration provides the opportunity for Central LHIN and its health service providers to build partnerships and improve system responsiveness and quality. Integrated models provide coordinated, accessible and high-quality health care that improves patient care and makes service delivery more efficient.

Local health system integrations are informed by the priorities of Central LHIN and its communities. Central LHIN is making progress to improve the sustainability of the health system by encouraging integrated service delivery and care models across sectors. Examples of local progress in 2011/12 towards these goals in our LHIN include:

Integration Name	Description/Partners	Integration Type	Central LHIN Planning Area
Sunnybrook Health Sciences Centre and St. John's Rehab Hospital	Amalgamation of St. John's Rehab Hospital services and funding under Sunnybrook Health Sciences Centre (Ongoing)	Voluntary	North York Central Region and Toronto Central LHIN
Etobicoke Services for Seniors, CANES Community Care and Peel Senior Link	Joint Venture Agreement to build agency capacity for the provision of services to seniors	Voluntary	North York West Region

Voluntary integrations are those initiated by health service providers and brought to the LHIN public Board meeting for review. In its review of voluntary integrations, Central LHIN applies a standard set of criteria based on obligations outlined in the *Local Health System Integration Act, (LHSIA), 2006*, including access, effectiveness, quality and coordination.

In addition, proposals are reviewed for transparency, fairness, accountability and risk mitigation. The LHIN also evaluates the actions taken by the health service providers to engage the community and affected stakeholders, as well as any human resources implications and mitigation strategies.

Central LHIN regularly monitors outcomes and the status of all health system integrations undertaken per LHSIA by requiring health service providers to report on their integration progress.

Health service providers are requested to provide both qualitative results on progress to date, as well as a quantitative analysis based on available data and any efficiency gains achieved.

St. John's Rehab Hospital and Sunnybrook Health Sciences Integration

In 2011, the Central and Toronto Central LHIN Boards of Directors considered the proposed amalgamation and integration of St. John's Rehab Hospital and Sunnybrook Health Sciences Centre at a joint public Board meeting. The amalgamation of these institutions has the opportunity to **improve the health outcomes and coordination of care for patients with complex health issues.** Central LHIN continues to work with the Toronto Central LHIN, the Ministry of Health and Long-Term Care and the two health service providers in consideration of this proposed integration.

Community engagement

Central LHIN continues to be a leader in promoting community engagement as a key vehicle to support the implementation of our IHSP and to advance provincial priorities, including the provincial quality agenda.

In 2011/12, Central LHIN hosted six major external community engagement sessions with a combined total participation of over 800 health service providers and stakeholders from across Ontario.

Central LHIN also convened a health service provider Community Engagement Task Group to develop the *Health Service Provider Community Engagement Guiding Principles & Checklist*, which outlines key principles to assist health service providers in their community engagement activities. The Guiding Principles and Checklist is essential for health service providers to support effective, high-quality community engagement across Central LHIN.

Cross-Ministry / LHIN engagement

Working across LHINs, local governments and with other ministries is an important part of the LHIN mandate to plan for a more integrated and high-quality health care system that focuses on the needs of the people, regardless of where they live or where their care needs are addressed in the continuum. Two key LHIN planning tables support these unique strategic partnerships.

First, the Central LHIN Complex Care Planning Group, created in collaboration with the Ministries of Community and Social Services and Children and Youth Services, is developing a strategy to address local system gaps to improve the delivery of community-based services for people with both complex medical and social support needs.

Second, the newly-established **Central LHIN Newcomer Settlement Planning Group** is working to identify and address current challenges faced by newcomers in accessing and navigating the health system, and will develop planning principles to help identify opportunities to align health system planning activities with settlement strategy development.

Additionally, the Central LHIN health equity priority identifies the specific objective of fostering joint planning with other ministries, such as the Ministries of Community and Social Services (MCSS), Children and Youth Services (MCYS) and other agencies, as appropriate.

In May 2011, Central LHIN, in partnership with MCSS and MCYS, hosted *Working Together to Improve Community-Based Complex Care Services*. Participants included representatives from long-term care homes, community support services, municipal governments, community mental health agencies, developmental services, supportive housing/assisted living providers and the Community Care Access Centre.

The themes and recommendations from the forum acknowledged the need for a multi-sectoral and interdisciplinary planning table to identify key priorities for effective and sustainable collaboration in community-based complex care.

Primary care engagement

Primary care is a key resource through which people access the health system. Our LHIN is home to two Nurse Practitioner Led Clinics, 11 Family Health Teams, two Community Health Centres and over 1,380 family physicians. Several additional Family Health Teams and Community Health Centres also have service locations in Central LHIN.

A Primary Care Action Group (PCAG) was established to help advance primary care engagement in Central LHIN. Through this group, Central LHIN supported opportunities that facilitated collaboration between sectors and enhanced system integration and patient navigation of the system.

Recognizing that primary care is an essential component of health care delivery and key to advancing strategic directions at both the provincial and local level, Central LHIN will continue to work closely with the Ministry of Health and Long-Term Care, the Ontario Medical Association and other LHINs to implement the Primary Care LHIN Lead Pilot Program.

Key Primary Care Action Group (PCAG) achievements included:

- ✓ Developed a process to **enhance collaboration** between primary care providers;
- ✓ Enabled **a 5% increase in the uptake of unattached patients** (i.e. through Health Care Connect);
- ✓ Developed engagement strategies **to enhance knowledge translation and capacity** in chronic disease management and prevention, mental health and addictions, and to support **enhanced integration** between hospitals, Central CCAC and primary care providers;
- ✓ Identified mechanisms to **improve patient outcomes through the transitions of care**; and
- ✓ Supported the **establishment of a Primary Care Community of Practice** to help facilitate knowledge exchange and sharing of best practices in primary care.

Championing better approaches to local quality primary care

Improving access to primary care for our residents and developing stronger linkages between primary care providers and other parts of the health system is a key quality priority for Central LHIN.

The introduction of Primary Care Leads in each of the 14 LHINs is a new initiative supported by the Ministry of Health and Long-Term Care and the Ontario Medical Association. Central LHIN appointed a **Primary Care Lead** in February 2012.

"Central LHIN has identified primary care as a critical enabler to support a high quality and integrated health care system. Engaged family physicians and nurse practitioners will continue to innovate and champion improved access to multidisciplinary care. Through their efforts, Central LHIN will benefit from improved electronic system integration, safe patient navigation at care transitions, and enhanced inter-sectoral collaboration."

– Dr. David Kaplan, Central LHIN Primary Care Lead

Engaging our Aboriginal community

Central LHIN is committed to engaging with members of the Aboriginal community to identify needs and promote culturally appropriate programs and services.

In 2011/12, Central LHIN, in collaboration with Georgina Island leaders and its community, conducted an engagement session to share best practices and develop partnerships to better support the health needs of our Aboriginal community. The themes and recommendations are being examined to determine their appropriate integration into Central LHIN primary care engagement activities and alignment with the provincial priorities; they will also be shared with other Central LHIN Advisory Networks and Action Groups, to be considered and integrated into the work plans of these groups.

Collaborating with our Francophone community

In 2011/12, Central LHIN welcomed the launch of the Entité de planification pour les services de santé en français #4 Centre Sud-Ouest (the **French Language Health Planning Entity** #4, the Entité).

In June 2011, the Entité signed a Joint Action Plan with Central, Central East and North Simcoe Muskoka LHINs, establishing a formal relationship among the stakeholders and outlining their mutual objectives. These include:

- Making information on French Service Providers easily accessible on each LHIN and the Entité's websites;
- Clarifying roles, responsibilities and the working relationship between the LHINs and the Entité;
- Engaging the francophone community on actions taken by each LHIN to achieve Integrated Health Service Plan (IHSP) strategic priorities; and

- Identifying long-term goals for improving access to French Language Services in each LHIN.

Implementing these objectives will help improve access to care for local francophone residents, support achievement of ED/ALC targets and develop a French training module for chronic disease self-management programs.

Central LHIN, along with Toronto Central, Central East and Mississauga Halton LHINs, has been working with the Regroupement des intervenantes et intervenants francophones en santé et en services sociaux de l'Ontario to increase the capacity of health services providers to develop a bilingual service capability, hire and retain bilingual personnel, and provide an active offer of services. These organizations plan on organizing training and information sessions in 2012 and onward.

Monitoring health service providers' capacity and compliance with French language services requirements is necessary to attain high quality health services. For this reason, Central LHIN developed and strengthened the reporting requirements for identified and non-identified health service providers to ensure compliance.

Through a joint Health Equity – French Language Services report, Central LHIN gained insight into our health service providers' capacity and activities in French language services compliance. Progress reports were submitted in November and December 2011, and Central LHIN has been building on the outcomes to support enhanced compliance and the ability to provide high quality care to the francophone community.

Additionally, Central LHIN recognizes the importance of access to information in French and continues to work to improve the accessibility of information, particularly on our bilingual website, launched in 2011, and through the translation of key materials.

In January 2012, Central LHIN participated in a community engagement session with the francophone community. The session was organized by the Entité and participants included les Centres d'Accueil Heritage and the Association of Francophones of York Region. These sessions helped solidify relationships and improve collaboration across sectors for French speaking members of our community. Additionally, input from the engagement sessions provides Central LHIN with information and perspectives to inform our planning.

Engaging local governments

Building relationships with our local communities includes reaching out to and responding to requests for information from our area MPPs and municipal government representatives. We welcome the opportunity to answer constituency questions, share information and meet with local leaders to foster greater understanding of the work we are all doing for people in our community.

This past year, Central LHIN hosted our annual MPP breakfast and annual Municipal Forum. These sessions gave Central LHIN's Chief Executive Officer and Board of Directors the opportunity to meet with and update local government representatives about our current activities and priorities, foster stronger relationships and continue our ongoing dialogue on local health issues and our shared commitment to improving the local health system.

Building local governance

Good governance is a fundamental requirement for organizations operating in today's complex health care environment. Central LHIN is committed to promoting and supporting our health service provider boards to share best practices and learn from one another.

In 2011/12, Central LHIN held four Governance Council meetings at various locations throughout the LHIN, all geared to developing governance-level relationships between our Board and the Chairs of our health service provider Boards.

These sessions inform health service provider Board Chairs about Central LHIN's actions and investments, and enable participants to discuss governance-level priorities and opportunities for collaboration.

eHealth

Central LHIN's Integrated Health Service Plan (IHSP) identifies eHealth as a key enabler for achieving LHIN, Ministry and health service provider priorities.

We believe strategic investments in information technology and information management (IT/IM) will provide secure access to clinical information and will support the delivery of high quality health care to people in our communities. These include:

Connecting GTA (cGTA)

cGTA is a partnership of the five GTA LHINs, with the goal to improve the patient and clinician experience by providing point-of-care access to electronic patient information from across the continuum.

In 2011/12, 12 health service providers across the province were selected as data contributors: within the Central LHIN, North York General Hospital and Central Community Care Access Centre (CCAC) were selected as participants.

Resource Matching and Referral (RM&R)

Thanks to the LHIN-wide RM&R system, patient referrals between acute care hospitals, St. John's Rehab and Central CCAC are now being managed electronically. This means people are being served faster, smarter and safer.

The deployment of RM&R is part of the province's commitment to create electronic health records for all Ontarians by 2015, and represents the next generation of the health care referral process.

Central LHIN RM&R

RM&R is streamlining processes, enhancing the safety and speed of our local health system's responsiveness to referral requests, and moving the quality agenda forward. **North York General Hospital was the first hospital in Canada to send referrals electronically from the Emergency Department to the CCAC via RM&R** and the system is now live across the LHIN.

Provincial RM&R

Central LHIN also participates in the Provincial RM&R project as part of Cluster 2. Phase 1 of the project was successfully completed and included LHIN-level Fuzion sessions – collaborative meetings with subject matter experts and key stakeholders, to validate current and future state workflows for specific RM&R pathways. The pathways currently in scope for the provincial project are:

- Acute (medical and surgical inpatient) to Rehabilitation;
- Acute (medical and surgical inpatient) to Complex Continuing Care;
- Acute (medical and surgical inpatient) to Long Term Care; and
- Acute (medical and surgical inpatient) to CCAC in-home services.

Hospital Report Manager

Central LHIN, along with eHealth Ontario, is working to advance the Hospital Report Manager. Once implemented, this tool will allow physicians to receive their patients' hospital discharge reports electronically into their electronic medical record (EMR).

Hospital Report Manager aims to eliminate the paper processes (mail, fax and scanning) that are currently required to receive these reports. It allows for the integration of information from the reports into EMR systems and reduce the time it takes for information to reach physicians. Central LHIN's Hospital Report Manager proposal was accepted by eHealth Ontario in 2011/12 and the project charter is currently being developed.

Hospital Diagnostic Imaging Repository Services (HDIRS)

The HDIRS is a project with 23 member hospitals. The goal of the project is to develop, implement and operate a shared diagnostic imaging repository, and contribute to the development of an Electronic Health Record for all Canadians. All Central LHIN community hospitals are members of HDIRS with the exception of Humber River Regional Hospital, which is a member of a similar project.

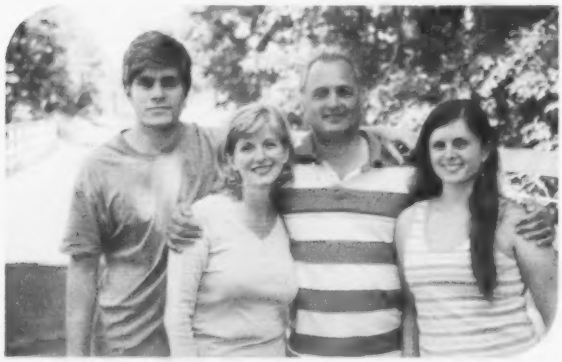
Community Care Information Management (CCIM) – Integrated Assessment Record (IAR)

A number of Central LHIN health service providers have implemented the IAR and many more are scheduled to do so. IAR is an application that allows electronic assessment information to move with the client from one health service provider to another; it also enables health service providers to view timely client assessment information electronically, securely and accurately – reducing the number of assessments required.

Advancing quality

In May 2011, Central LHIN released *Patients First: Emerging Themes*, a compilation of findings from the March 2011 Quality Symposium, which included reflections on key themes for improving care transitions. In response to the findings and recommendations outlined in the report in August 2011, Central LHIN released *Patients First: An Action Plan to Improve Quality in the Transitions of Care.*

This Quality Action Plan aligns with the Central LHIN strategic plan and provincial quality directions and supports the implementation of the *Excellent Care for All Act (ECFAA), 2010.* The plan has been designed to support an integrated approach to quality improvement that can be replicated across LHINs to achieve system level improvements and quality outcomes.



The Quality Action Plan also includes a range of initiatives identified in the Central LHIN Integrated Health Service Plan (IHSP) 2010-2013, provincial priorities, as well as new quality-focused initiatives designed to improve patient safety and flow across the system.

The Central LHIN Quality Action Plan includes **three main areas of focus to advance our collective quality direction**. These are:

- Strengthening relationships to support a culture of quality improvement through Health Service Provider Quality Collaboratives;
- Standardizing hospital discharge processes; and
- Developing indicators for transitions of care.

The three corresponding overall **strategic goals** underpinning the Quality Action Plan include improved patient outcomes and overall quality of care; improved access to care; and improved system performance (with a particular focus on Alternate Level of Care).

In September 2011, Central LHIN held its first Health Service Provider Quality Collaborative, *Improving Quality in Emergency Departments by Enhancing Flow*. The event explored the linkages between longer lengths of stay and patient quality/outcomes, with the goal to identify organizational and system-wide strategies for improvement in Central LHIN hospitals.

The second Quality Collaborative, *Advancing Infection Prevention and Control Best Practices in the Emergency Department* was held in December 2011, and enabled health service providers and subject matter experts to collectively explore the linkages between infection prevention and control precautions, as well as their impact on lengths of stay in the emergency department.

Planning is underway for future Quality collaboratives. Upcoming engagements will address advancing quality in primary care, discharge planning, transitions of care and mental health and additions. Central LHIN continues to work closely with Health Quality Ontario and the Ministry of Health and Long-Term Care to support *ECFAA* implementation.

Central LHIN's Quality Action Plan: **Empowering a local health care system to provide the right care, in the right place, at the right time**

Financial statements of

Central Local Health Integration Network

March 31, 2012

Central Local Health Integration Network

March 31, 2012

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Independent Auditor's Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the accompanying financial statements of the Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of operations, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2012, and the results of its operations, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 29, 2012

Central Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	783,009	774,718
Due from Ministry of Health and Long-Term Care ("MOHLTC")	1,864,300	5,048,235
Accounts receivable	31,412	25,974
	2,678,721	5,848,927
Liabilities		
Accounts payable and accrued liabilities	290,049	490,967
Due to Health Service Providers ("HSPs")	1,864,300	5,048,235
Due to Ministry of Health and Long-Term Care ("MOHLTC") (Note 3)	445,234	349,029
Due to the LHIN Shared Services Office (Note 4)	98,795	2,152
Deferred capital contributions (Note 5)	167,740	203,312
	2,866,118	6,093,695
Commitments (Note 6)		
Net debt	(187,397)	(244,768)
Non-financial assets		
Prepaid expenses	19,657	41,456
Capital assets (Note 7)	167,740	203,312
	187,397	244,768
Accumulated surplus	-	-

Approved by the Board

_____ Director

_____ Director

Central Local Health Integration Network

Statement of operations
year ended March 31, 2012

	Budget (Unaudited - Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,730,059,133	1,824,986,446	1,760,411,514
LHIN Operations and Programs			
Operations of LHIN	4,409,616	4,107,734	4,288,477
Emergency Room/Alternative Level of Care ("ER - ALC") Funding (Note 10a)	100,000	100,000	100,000
Primary Care Lead (Note 10b)	43,750	15,625	-
Aboriginal Initiative (Note 10c)	10,000	728	127
Behavourial Supports Ontario (Note 10d)	57,000	31,373	-
Emergency Department Lead (Note 10e)	75,000	72,000	54,000
French Language Services (Note 10f)	-	-	40,631
French Language Health Services (Note 10g)	106,000	93,321	18,459
Critical Care Lead (Note 10h)	75,000	72,229	72,750
E-Health Ontario funding (Note 10i)	350,000	338,122	294,090
Amortization of deferred capital contributions (Note 5)	90,000	81,541	123,021
Total LHIN Operations and Programs	5,316,366	4,912,673	4,991,555
	1,735,375,499	1,829,899,119	1,765,403,069
Expenses			
Transfer payments to HSPs (Note 9)	1,730,059,133	1,824,986,446	1,760,411,514
Operations			
General and administrative (Note 11)	4,409,616	4,107,734	4,288,477
ER - ALC funding (Note 10a)	100,000	100,000	100,000
Primary Care Lead (Note 10b)	43,750	15,625	-
Aboriginal Initiative (Note 10c)	10,000	728	127
Behavourial Supports Ontario (Note 10d)	57,000	31,373	-
Emergency Department Lead (Note 10e)	75,000	72,000	54,000
French Language Services (Note 10f)	-	-	40,631
French Language Health Services (Note 10g)	106,000	93,321	18,459
Critical Care Lead (Note 10h)	75,000	72,229	72,750
E-Health (Note 10i)	350,000	338,122	294,090
Amortization of capital assets	90,000	81,541	123,021
	1,735,375,499	1,829,899,119	1,765,403,069
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012		2011
	Budget (Unaudited - Note 8)	Actual	Actual
	$	$	$
Annual surplus	-	-	-
Acquisition of capital assets	25,000	45,969	121,145
Amortization of capital assets	(90,000)	(81,541)	(123,021)
Change in other non-financial assets	-	(21,799)	37,224
Decrease in net debt	(65,000)	(57,371)	35,348
Opening net debt	244,768	244,768	209,420
Closing net debt	179,768	187,397	244,768

Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**(81,541)**	(123,021)
Amortization of deferred capital contributions (Note 5)	**81,541**	123,021
	-	-
Changes in non-cash operating items		
Increase/(decrease) in due from MOHLTC	**3,183,935**	(1,945,166)
Decrease/(increase) in accounts receivable	**(5,438)**	40,659
Decrease in accounts payable and accrued liabilities	**(200,918)**	(188,955)
Increase in due to the MOHLTC	**96,205**	348,648
(Decrease)/ increase in due to HSPs	**(3,183,935)**	1,945,166
Increase in due to the LHIN Shared Services Office	**96,643**	2,152
Decrease in due from LHIN Shared Services Office	-	3,643
(Decrease) in deferred revenue	-	(54,042)
Increase/ (decrease) in prepaid expenses	**21,799**	(37,224)
	8,291	114,881
Capital transaction		
Acquisition of capital assets	**(45,969)**	(121,145)
Financing transaction		
Deferred capital contributions received (Note 5)	**45,969**	121,145
Net increase in cash	**8,291**	114,881
Cash, beginning of year	**774,718**	659,837
Cash, end of year	**783,009**	774,718

1. Description of business

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandate of the LHIN is to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with health service providers.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers have flowed through the LHIN's financial statements. Throughout the years, funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues and expenses in the fiscal year that the events giving rise to the revenues or expenses occur, and the revenues and expenses are earned or incurred and measurable. Through the accrual basis of accounting expenses include non-cash items, such as the amortization of capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the Performance Agreement, the LHIN is economically dependent on the MOHLTC.

Effective April 1, 2007, the LHIN assumed responsibility to authorize transfer payments to Health Service Providers. The transfer payment amounts are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

The LHIN Financial Statements do not include any MOHLTC managed programs, under which the Health Service Provider is directly accountable to the MOHLTC

2. Significant accounting policies (continued)

eHealth Ontario Funding

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

Government transfers

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the transfer is authorized and all eligibility criteria have been met, except when and to the extent that the transfer gives rise to an obligation and a liability is recorded.

Transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work.

Deferred capital contributions

Amounts received that are used to fund capital asset purchases are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset. The amount recorded as revenue in the Statement of Financial Activities is consistent with the amortization expense of the related capital asset.

Capital assets

Capital assets are recorded at cost. Cost includes the purchase price of the asset and other acquisition costs such as design, construction, and duties. Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of Financial Statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the Financial Statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Revenue has only been recognized to the extent that eligible expenditures have been incurred. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the eHealth Ontario.

Funding repayable to the MOHLTC and eHealth is as follows:

			2012	2011
	Funding received	Revenue recognized	Repayable	Repayable
	$	$	$	$
Transfer payments to HSPs	1,824,986,446	1,824,986,446	-	-
LHIN operations	4,409,616	4,107,734	301,882	-
eHealth	400,000	338,122	61,878	
Special program funding	466,750	385,276	81,474	349,029
	1,830,262,812	1,829,817,578	445,234	349,029

4. Related party transactions

In accordance with the Memorandum of Understanding between the MOHLTC and the LHIN, LHINs are required to centrally source and share services for Legal Services, Audit Services, HR Services, IM & IT Infrastructure Development and Management and Management of Recorded Information. The LHINS accordingly formed the LHIN Shared Services Office ("LSSO") as a division of the Toronto Central LHIN. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LSSO operating under paid by the LHIN at year end is recorded as a payable to the LSSO.

The LHIN Collaborative (LHINC) was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LHINC operating costs overpaid (or under paid) by the LHINs at year end, are recorded as a receivable (payable) from (to) the LHINC.

During the year, the LHIN made payments to LSSO and LHINC of $501,995 (2011 - $409,523).

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	203,312	205,188
Capital contributions received during the year	45,969	121,145
Amortization for the year	(81,541)	(123,021)
Balance, end of year	167,740	203,312

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	$	$	$
2013	236,767	7,633	244,400
2014	255,784	7,633	263,417
2015	272,876	-	272,876
2016	290,293	-	290,293
2017 and after	24,312	-	24,312

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

7. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	360,539	261,093	99,446	98,988
Computer equipment	124,229	99,774	24,455	54,574
Leasehold improvements	58,567	14,728	43,839	49,750
	543,335	375,595	167,740	203,312

8. Budget figures

Budget amounts have been reported in the Statement of Financial Operations to comply with PSAB reporting requirements and reflect the initial budget at April 1, 2011. The budgets were approved by the Government of Ontario.

	$
LHIN total budget	1,735,375,499
Less Health Service Provider Budget (a)	(1,730,059,133)
LHIN Operating Budget (b)	5,316,366

8. Budget figures (continued)

a) Health Service Provider Budget

	$
Initial HSP Budget	1,730,059,133
Adjustments due to announcements made during the year	94,927,313
	1,824,986,446
The total budget by sector is as follows:	
Hospitals	1,135,136,035
Long Term Care Homes	311,945,250
Community Care Access Centres	229,474,894
Community Support Services	71,997,394
Community Health Centres	8,500,437
Community Mental Health and Addictions	67,932,436
Total budget	1,824,986,446

b) LHIN Operating Budget

	$
Initial budget as reported on the statement of operations	5,316,366
Additional funding received in-year:	
Funding for capital asset purchased transferred to deferred capital contributions	(25,000)
Closing budget	5,291,366

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of $1,824,986,446 (2011 - $1,760,411,514) to the following sectors:

	2012	2011
	$	$
Hospitals	**1,135,136,035**	1,106,535,927
Long Term Care Homes	**311,945,250**	296,523,547
Community Care Access Centres	**229,474,894**	214,073,634
Community Support Services	**71,997,394**	69,137,969
Community Health Centres	**8,500,437**	7,666,837
Community Mental Health and Addictions	**67,932,436**	66,473,600
	1,824,986,446	1,760,411,514

10. Operations of LHIN

a) Emergency Response - Alternate Level of Care (ER-ALC)

The LHIN received funding of $100,000 (2011 - $100,000) for the Emergency Response - Alternate Level of Care project. The following are the expense details:

	2012	2011
	$	$
Salaries and benefits	98,130	97,646
Accommodation and administration	599	895
Supplies and other	1,271	1,459
	100,000	100,000

b) Primary Care LHIN Lead

The LHIN received one time funding of $43,750 (2011 - Nil) to support Primary Care LHIN Lead. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Consulting services	15,625	-
	15,625	-

c) Aboriginal initiative

The LHIN received net funding of $10,000 (2011 - $7,000) related to the Aboriginal Planning initiative. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Accommodation and administration	-	74
Supplies and other	728	53
	728	127

d) Behavourial Supports Ontario

The LHIN received one time funding of $57,000 (2011 - $Nil) to support the Behavourial Supports Ontario program. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	26,265	-
Accommodation and administration	5,108	-
	31,373	-

10. Operations of LHIN (continued)

e) Emergency department (ED) lead project

The LHIN received funding of $ 75,000 (2011 - $75,000) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2012	2011
	$	$
Consulting services	72,000	54,000
	72,000	54,000

f) French Language Services

The LHIN did not receive funding in fiscal years 2012 or 2011 to support Francophone community engagement activities. $40,631 of funding received in fiscal 2010 was spent on this initiative in fiscal year 2011.

	2012	2011
	$	$
Public relations	-	39,680
Accommodation and administration	-	951
	-	40,631

g) French Language Health Services

The LHIN received funding of $106,000 (2011 - $31,455) to support the implementation of French Language Health Services. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	91,421	17,695
Accommodation and administration	1,900	764
	93,321	18,459

h) Critical Care LHIN Lead

The LHIN received one time funding of $75,000 (2011 - $75,000) to support Critical Care LHIN Lead. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Consulting services	72,000	72,750
Accommodation and administration	229	-
	72,229	72,750

10. Operations of LHIN (continued)

i) E-health

The LHIN received funding of $350,000 (2011 - $600,000) from eHealth Ontario specifically related to the e-health projects. E-health expenses incurred during the year are as follows

	2012	2011
	$	$
Salaries and benefits	314,247	272,591
Consulting services	19,320	-
Accommodation and administration	4,555	17,172
Supplies and other	-	4,327
	338,122	294,090

11. General and administrative expenses

The Statement of Operations presents the expenses by function. The following table classifies the general and administrative expenses by object:

	2012	2011
	$	$
Salaries and benefits	3,010,986	3,159,718
Occupancy	187,505	242,485
Shared services	501,995	409,523
Public relations	54,548	104,408
Consulting services	15,000	53,798
Professional Services	18,996	13,660
Supplies	70,770	43,871
Board expenses (see below)	94,441	142,069
Mail, courier and telecommunications	45,368	37,939
Other	108,125	81,006
	4,107,734	4,288,477

Board expenses included in general operating expenses above include per diem costs and other Board expenses as follows:

	Budget 2012	2012	2011
	$	$	$
Board Chair per diem expense	40,000	40,100	41,725
Other Board members per diem expense	50,000	22,800	47,445
Governance costs and travel	59,300	31,541	52,899
	149,300	94,441	142,069

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 23 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $274,515 (2011 - $243,135) for current service costs and is included as an expense in the Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2011. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative numbers have been reclassified to conform to the current year presentation.

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